

FILED DEC 18 1950

318

PRIMARY REG. DIST. NO.

1003

State File No.

42003

10380

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 2328 CARR ST.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hosp.							
3. NAME OF DECEASED (Type or Print) a. (First) HARVEY		b. (Middle) _____		c. (Last) Bennett		4. DATE OF DEATH (Month) (Day) (Year) 12-4-50	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Bachelor		8. DATE OF BIRTH MAR. 10-95	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) LABORER		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME HARVEY BENNETT		13b. MOTHER'S MAIDEN NAME Katie Little		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mildred Reed		ADDRESS 4327 Gayfield	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumococcal Meningitis DUE TO (c) Right Lobe Pneumonia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 490X			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:30 A. M. , from the causes and on the date stated above.							
23a. SIGNATURE Charles E. Layman (Degree or title) _____				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 12.5.50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 12-8-50		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.	
DATE REC'D BY LOCAL REG. DEC 6 1950		REGISTRAR'S SIGNATURE J. B. Satter		25. FUNERAL DIRECTOR'S SIGNATURE Dement & Son		ADDRESS 2631 Cole St.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.